



**APPLICATION FOR DISABILITY RETIREMENT**  
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
 SFN 18000 (Rev. 10-2011)

**NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657**  
**(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920**

<b>PART A PARTICIPANT IDENTIFICATION</b>	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

**PART B OTHER BENEFITS**

Are you eligible to receive the following benefits? Please check and complete the appropriate boxes.

YES	NO	BENEFITS	Date Benefits Began	Date Benefits Terminate	Amount	Paid Weekly	Paid Monthly
		Workers Compensation Benefits?					
		Unemployment Compensation Disability?					
		Sick Pay?					
		Social Security Benefits?					
		Retirement Income (Current or Past Employers?)					

Has Social Security Been Applied For?  Yes  No      Has Worker's Compensation Benefits Been Applied For?  Yes  No

**PART C APPLICATION FOR DISABILITY BENEFITS**

**SECTION 1 RETIREMENT PAYMENT OPTION (Check One)**

MainSystem, Law Enforcement, or National Guard	Highway Patrol or Judges	Defined Contribution Plan
<input type="checkbox"/> Single Life <input type="checkbox"/> 50% Joint Survivor/Life <input type="checkbox"/> 100% Joint Survivor/Life <input type="checkbox"/> 10 Year Term Certain/Life <input type="checkbox"/> 20 Year Term Certain/Life	<input type="checkbox"/> Normal Retirement <input type="checkbox"/> 100% Joint Survivor/Life <input type="checkbox"/> 10 Year Term Certain/Life <input type="checkbox"/> 20 Year Term Certain/Life	<input type="checkbox"/> Periodic Retirement Payment <b>A TIAA-CREF Distribution Form MUST be completed and accompany this application.</b>

**SECTION 2 RETIREE HEALTH INSURANCE CREDIT OPTION (Check One)**

I elect the standard retiree health credit option specific to the retirement payment option selected in section 1.

If married and selected the Single Life, 20 or 10 Year Term Certain, or a Defined Contribution Periodic payment; I elect the following alternate actuarially reduced retiree health credit option.

(Check One):  50% Joint Survivor Life  
 100% Joint Survivor Life

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<b>PART D SICKNESS OR INJURY DATA</b>			
Date of Sickness or Injury	Date You First Noticed Symptoms	Date You First Saw a Physician For This Sickness or Injury	
Cause of Disability			
Name of Treating Physician (If more than one, list on separate sheet of paper.)			
Address		City	State      Zip Code + 4
If Hospitalized For Sickness or Injury, Give Name of Hospital		Date Admitted	Date Released
Are You Bed Confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are You House Confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have You Ever Had The Same Kind of Sickness or Injury Before? <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify date and physician's name and address below.	
Date of Accident?	Time of Accident?	Was Accident Work Related?	Where Did The Accident Occur?
Date You Were First Able To Leave Home For Any Purpose?		Date You Were First Able To Do Any Part Of Your Work, Supervisory or Otherwise?	

<b>PART E EDUCATION</b>		
Last Year Completed	Name of School	
Last Year in School	Degree/Certificate	Additional Training
Attitude Towards School <input type="checkbox"/> Like <input type="checkbox"/> Dislike	Favorable Courses	

<b>PART F MILITARY SERVICE</b>		
Branch	Date From:                      To:	Discharge <input type="checkbox"/> Honorable <input type="checkbox"/> General <input type="checkbox"/> Other (Specify)
Duties/Responsibilities		
Rank	Special Training	
Service Connected Disabilities		

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<b>PART G WORK HISTORY (List Most Recent First)</b>		
Employer	Supervisor	
Job Title(s)		
Dates: From:                      To:	Salary	Duties
Employer	Supervisor	
Job Title(s)		
Dates: From:                      To:	Salary	Duties
Employer	Supervisor	
Job Title(s)		
Dates: From:                      To:	Salary	Duties

## **PART H MEMBER AUTHORIZATION**

**Release of Information:**  
 To all physicians and other medical professionals, hospitals, and other medical-care, institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators:

You are authorized to provide MidDakota Clinic and any benefit plan administrators, consumer reporting agencies, attorneys, and independent claim administrators acting on MidDakota Clinic's behalf with information concerning medical care, advice, treatment, or supplies provided the patient, including information relating to mental illness and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administrating claims for benefits.

In understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I elect to receive the retirement benefits and health credit as indicated in PART C. I understand I must submit a photocopy of my birth certificate. (If married, also submit a photocopy of spouse's birth certificate & marriage certificate)

**I understand that this application for Disability Retirement SFN 18000 must be received by NDPERS at least 30 days before distribution of my first retirement check and within 12 months of termination of NDPERS covered employment.**

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_